MDR Tracking Number: M5-04-3725-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on June 29, 2004.

Based on correspondence from the requestor, Ergonomic Rehabilitation of Houston, dated, 10-04-04, CPT code 99082 for date of service 08-01-03 has been withdrawn and will not be addressed in this review.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The work hardening-initial and work hardening, each additional hour for 06-30-03 through 08-08-03 **were found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This Findings and Decision is hereby issued this 8th day of October 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 06-30-03 through 08-08-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 8th day of October 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/pr

NOTICE OF INDEPENDENT REVIEW DECISION

September 9, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-3725-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 33 year-old male was injured when he was struck in the chest by a wrecking ball hanging from a crane on ___. His diagnoses are acute traumatic lumbar intervertebral disc (IVD) syndrome, acute traumatic thoracic segmental dysfunction, acute internal derangement of the right shoulder, crush injury to the chest and abdomen, and paravertebral myofascitis. He has been treated with therapy, epidural steroid injections, and medications.

Requested Service(s)

Work hardening-initial, work hardening-each additional hour for dates of service 06/30/03 through 08/08/03

Decision

It is determined that the work hardening-initial and work hardening, each addition hour for dates of service 06/30/03 through 08/08/03 were medically necessary to treat this patient’s condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient suffered a very traumatic physical injury but also suffered from depression, return to work anxiety and fear of re-injury. The multi-disciplinary approach is both beneficial and medically necessary for this type of injury. The psychological group sessions of the work hardening program are necessary and successful in helping patients overcome problems of returning to work at full duty. Therefore, the work hardening program this patient attended was both beneficial and medically necessary to treat this patient’s medical condition.

Sincerely,